		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011643

Facility Name: SUNSET HOME

Address: 418 WASHINGTON (Number) QUINCY (City) 62301 (Zip Code)

County: ADAMS

Telephone Number: 217-223-2636 **Fax #** 217-223-9867

IDPA ID Number: 370661224-001

Date of Initial License for Current Owners: NOT AVAILABLE

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: RUTH STOWE **Telephone Number:** 217-223-2636 EXT 311

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/01 to 9/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 11/18/2002 (Date)
(Type or Print Name) JUDY KIRLIN
(Title) CEO/ADMINISTRATOR

Paid Preparer

(Signed) _____ 11/18/2002 (Date)
(Print Name and Title) TIMOTHY WIEWEL, PROPRIETOR
(Firm Name & Address) TIMOTHY J WIEWEL CPA, PO BOX 1028 QUINCY IL 62306
(Telephone) 217-223-2245 Fax # 217-223-7580

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 248

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	19	Skilled (SNF)	19	5,840	1
2		Skilled Pediatric (SNF/PED)			2
3	148	Intermediate (ICF)	148	54,020	3
4		Intermediate/DD			4
5	81	Sheltered Care (SC)	81	29,565	5
6		ICF/DD 16 or Less			6
7	248	TOTALS	248	89,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	493	36	1,964	2,493	8
9	SNF/PED					9
10	ICF	24,998	30,408		55,406	10
11	ICF/DD					11
12	SC	3,067	14,068		17,135	12
13	DD 16 OR LESS					13
14	TOTALS	28,558	44,512	1,964	75,034	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.91%

D. How many bed-hold days during this year were paid by Public Aid? 233 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
INDEPENDENT LIVING UNITS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started / /

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 9 and days of care provided 1,964

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	501,656	34,653	10,426	546,735		546,735		546,735			1
2	Food Purchase		246,820		246,820		246,820		246,820			2
3	Housekeeping	230,272	39,141	4,673	274,086		274,086		274,086			3
4	Laundry	58,569	17,939	75,853	152,361		152,361		152,361			4
5	Heat and Other Utilities			304,821	304,821		304,821		304,821			5
6	Maintenance	160,516	35,926	80,690	277,132		277,132		277,132			6
7	Other (specify):*											7
8	**TOTAL General Services**	951,013	374,479	476,463	1,801,955		1,801,955		1,801,955			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,082,427	162,764	33,182	3,278,373		3,278,373		3,278,373			10
10a	Therapy	188,929	3,092	38,026	230,047		230,047		230,047			10a
11	Activities	135,593	7,077	6,203	148,873		148,873		148,873			11
12	Social Services	81,030	90	2,165	83,285		83,285		83,285			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,487,979	173,023	79,576	3,740,578		3,740,578		3,740,578			16
	C. General Administration											
17	Administrative	75,086			75,086		75,086		75,086			17
18	Directors Fees											18
19	Professional Services			29,730	29,730		29,730	(686)	29,044			19
20	Dues, Fees, Subscriptions & Promotions			46,100	46,100		46,100		46,100			20
21	Clerical & General Office Expenses	285,635	8,676	119,071	413,382	(1,212)	412,170	(7,111)	405,059			21
22	Employee Benefits & Payroll Taxes			979,896	979,896	(10,067)	969,829		969,829			22
23	Inservice Training & Education					1,212	1,212		1,212			23
24	Travel and Seminar			24,139	24,139		24,139	(1,666)	22,473			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			115,734	115,734		115,734		115,734			26
27	Other (specify):* BAD DEBT			381	381		381	(381)				27
28	**TOTAL General Administration**	360,721	8,676	1,315,051	1,684,448	(10,067)	1,674,381	(9,844)	1,664,537			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,799,713	556,178	1,871,090	7,226,981	(10,067)	7,216,914	(9,844)	7,207,070			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SUNSET HOME #0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			410,836	410,836	(40,772)	370,064		370,064			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,325	6,325		6,325	(764)	5,561			32
33	Real Estate Taxes			552	552		552		552			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			417,713	417,713	(40,772)	376,941	(764)	376,177			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,113		28,113		28,113		28,113			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,433	91,433		91,433		91,433			42
43	Other (specify):* SEE ATTACHED			134,047	134,047	50,839	184,886	(184,886)				43
44	**TOTAL Special Cost Centers**		28,113	225,480	253,593	50,839	304,432	(184,886)	119,546			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,799,713	584,291	2,514,283	7,898,287		7,898,287	(195,494)	7,702,793			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(764)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,111)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(686)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(381)	27		24
25	Fund Raising, Advertising and Promotional	(99,608)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(85,478)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (194,028)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (194,028)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SUNSET HOME

ID# 0011643

Report Period Beginning: 10/1/01

Ending: 9/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VILLA INDEP LIVING	$ (85,278)	43	1
2	OUT OF STATE TRAVEL	(200)	24	2
3	2003 SEMINAR PAID 2002	(1,466)	24	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(86,944)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10/1/01 **Ending:** 9/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(686)	0	0	0	0	0	0	0	0	0	0	(686)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(7,111)	0	0	0	0	0	0	0	0	0	0	(7,111)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,666)	0	0	0	0	0	0	0	0	0	0	(1,666)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(381)	0	0	0	0	0	0	0	0	0	0	(381)	27
28	**TOTAL General Administration**	(9,844)	0	0	0	0	0	0	0	0	0	0	(9,844)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,844)	0	0	0	0	0	0	0	0	0	0	(9,844)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10/1/01 **Ending:** 9/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(764)	0	0	0	0	0	0	0	0	0	0	(764)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(764)	0	0	0	0	0	0	0	0	0	0	(764)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(184,886)	0	0	0	0	0	0	0	0	0	0	(184,886)	43
44	**TOTAL Special Cost Centers**	(184,886)	0	0	0	0	0	0	0	0	0	0	(184,886)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(195,494)	0	0	0	0	0	0	0	0	0	0	(195,494)	45

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MERCANTILE		X	OPERATIONS LINE OF CREDIT		8/3/00	$ 150,000	$	12/21/2007	0.0475	$ 5,561	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 150,000	$			$ 5,561	9
	B. Non-Facility Related*											
10	GIDT ANNUITIES		X	NONE							764	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 764	14
15	TOTALS (line 9+line14)						$ 150,000	$			$ 6,325	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 552	2
3. Under or (over) accrual (line 2 minus line 1).	$ 552	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 552	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001	552	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SUNSET HOME COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0011643

CONTACT PERSON REGARDING THIS REPORT RUTH STOWE

TELEPHONE 217-223-2636 EXT 311 FAX #: 217-223-9867

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-2-0917-000-00	700 S 5TH	$ 77.00	$ 77.00
2.	23-2-0973-000-00	810 S 4TH	$ 18.00	$ 37.00
3.	23-2-0972-000-00	812 S 4TH	$ 285.00	$ 285.00
4.	23-2-0926-000-00	701 S 4TH	$ 153.00	$ 153.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 533.00	$ 552.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 144,818 B. General Construction Type: Exterior BRICK Frame STEEL-FIREPROOF Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

VILLA APARTMENTS 16-2 BEDROOM UNITS 16,000 SQ FT

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	199,487		$ 102,419	1
2	PARKING LOT ADDITIONAL	15,000	1996-97	86,288	2
3	TOTALS	214,487		$ 188,707	3

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	34		1958	1958	$ 354,000	$ 7,080	50	$ 7,080	$	$ 315,060	4
5	117		1971	1971	1,218,562	24,371	50	24,371		755,481	5
6	49		1972	1972	472,577	9,452	50	9,452		290,641	6
7	5		1987	1987	68,497	3,425	20	3,425		51,660	7
8	43		2001	2001	2,500,281	83,343	30	83,343		83,343	8
	Improvement Type**										
9	BUILDINGS & IMPROVEMENTS			1958	12,000		10			12,000	9
10	BUILDINGS & IMPROVEMENTS			1972	51,124	1,023	50	1,023		30,681	10
11	BUILDINGS & IMPROVEMENTS			1977	14,179		20			14,179	11
12	BUILDINGS & IMPROVEMENTS			1978	442,103	8,842	50	8,842		216,745	12
13	BUILDINGS & IMPROVEMENTS			1979	13,639	273	50	273		6,413	13
14	BUILDINGS & IMPROVEMENTS			1980	771		20			771	14
15	BUILDINGS & IMPROVEMENTS			1981	7,902		10			7,902	15
16	BUILDINGS & IMPROVEMENTS			1982	13,900		10			13,900	16
17	BUILDINGS & IMPROVEMENTS			1983	17,260	863	20	863		16,672	17
18	BUILDINGS & IMPROVEMENTS			1985	272,013	6,800	40	6,800		117,749	18
19	BUILDINGS & IMPROVEMENTS			1987	321,886	14,347	10,20	14,347		258,492	19
20	BUILDINGS & IMPROVEMENTS			1988	36,315	239	10,20	239		35,024	20
21	BUILDINGS & IMPROVEMENTS			1989	164,241	7,313	10,20	7,313		118,071	21
22	BUILDINGS & IMPROVEMENTS			1990	64,734	3,237	20	3,237		39,877	22
23	BUILDINGS & IMPROVEMENTS			1992	11,222	967	10,20	967		9,643	23
24	BUILDINGS & IMPROVEMENTS			1993	37,801	2,214	5,10,20	2,214		23,569	24
25	BUILDINGS & IMPROVEMENTS			1994	9,466	382	5,20	382		5,074	25
26	BUILDINGS & IMPROVEMENTS			1995	99,649	6,990	5,10,15	6,990		55,929	26
27	BUILDINGS & IMPROVEMENTS			1996	33,788	1,256	5,20	1,256		16,394	27
28	BUILDINGS & IMPROVEMENTS			1997	403,089	21,357	5,10,20	21,357		125,373	28
29	BUILDINGS & IMPROVEMENTS			1998	107,004	5,930	5,10,20	5,930		26,686	29
30	DRAPES 457 & 271 WEST			1999	986	99	10	99		345	30
31	BLINDS ROOM 157 & MINIS ICE CREAM SHOP			1999	710	71	10	71		249	31
32	VERTICAL BLINDS OFFICE 1 WEST			1999	1,988	199	10	199		696	32
33	FIRE PROTECTION BOXES ON LIGHTS			2000	23,606	1,180	20	1,180		2,361	33
34	TILE 1 WEST AND S WEST HALLS			2000	4,633	232	20	232		463	34
35	DRYWALL SUNSET HALL			2000	4,600	230	20	230		230	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	TILE SUNSET HALL	2000	$ 2,605	$ 130	20	$ 130	$	$ 130	37
38	WINDOW BLINDS VALANCES 2 NORTH	2001	4,445	445	10	445		667	38
39	SHADES FOR SCU CORNER WINDOWS	2001	1,282	128	10	128		192	39
40	GATES SCU	2001	1,685	112	15	112		169	40
41	NURSES STATION 2 NORTH	2001	1,550	78	20	78		116	41
42	AUTO DOOR SMOKE ROOM 1SW RESIDENTS	2001	2,596	260	10	260		389	42
43	NURSES FRONT DESK	2001	975	24	20	24		24	43
44	NW FRONT DOOR LOBBY AUTOMATIC WEST	2001	2,173	109	10	109		109	44
45	REROOF BOILER & CHILLER AREA	2001	9,415	471	10	471		471	45
46	COURT YARD GARDEN DOOR & ELECTRIC STRIKE	2002	3,422	171	10	171		171	46
47	HOLLOW METAL DOORS	2002	4,573	229	10	229		229	47
48	REROOF CHAPEL	2002	3,600	180	10	180		180	48
49	REROOF KITCHEN & CAFETERIA	2002	18,300	915	10	915		915	49
50	KITCHEN FREEZER DEFROSTER TIMER	2002	1,115	56	10	56		56	50
51	PLANK FLOOR 2ND FLOOR	2002	4,487	224	10	224		224	51
52	REMODEL BEAUTY SHOP	2002	4,722	236	10	236		236	52
53									53
54	FIXED EQUIPMENT	1971	814,827		25			814,827	54
55	FIXED EQUIPMENT	1972	253,064		25			253,063	55
56	FIXED EQUIPMENT	1978	280,726	11,229	25	11,229		275,353	56
57	FIXED EQUIPMENT	1979	13,938		10			13,938	57
58	FIXED EQUIPMENT	1984	23,531		10			23,531	58
59	FIXED EQUIPMENT	1985	117,689	5,615	5,10,15,20	5,615		102,945	59
60	FIXED EQUIPMENT	1986	15,456	8	10,15	8		15,455	60
61	FIXED EQUIPMENT	1987	12,320	421	10,15,20	421		10,746	61
62	FIXED EQUIPMENT	1988	8,162	241	10,20	241		6,881	62
63	FIXED EQUIPMENT	1989	4,670	311	15	311		4,201	63
64	FIXED EQUIPMENT	1993	259,307	14,040	10,20	14,040		129,965	64
65	FIXED EQUIPMENT	1995	188,017	9,657	10,15,20	9,657		69,602	65
66	FIXED EQUIPMENT	1996	10,809	1,037	10,15	1,037		6,088	66
67	FIXED EQUIPMENT	1997	35,461	1,812	15,20	1,812		9,654	67
68	FIXED EQUIPMENT	1998	180,143	9,222	15,20	9,222		41,419	68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,069,591	$ 269,076		$ 269,076	$	$ 4,433,619	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,069,591	$ 269,076		$ 269,076	$	$ 4,433,619	1
2	UPGRADE 4S&N FIRE ALARM MODULES	1999	3,404	170	20	170		596	2
3	CALL LIGHT SYSTEM 2 WEST	1999	5,340	356	15	356		890	3
4	SMOKE DETECTORS DINING ROOMS 2,3,4	2000	2,524	168	15	168		421	4
5	POWER WIRING UPGRADE EMERGENCY GENERATOR	2000	10,100	505	20	505		1,263	5
6	REPLACE SEPARATOR KITCHEN CHILLER	2000	2,720	136	20	136		340	6
7	NEW CHILLER REPLACEMENT	2000	208,923	10,446	20	10,446		26,115	7
8	KEY LOCKS & PULLS TO WINDOWS SCU	2000	2,160	144	15	144		360	8
9	SPEAKERS/ AMP SCU	2000	2,546	170	15	170		170	9
10	TELEPHONE SYSTEM SCU	2000	2,695	270	10	270		270	10
11	REMOVE INSTALL BOILER CENTER SECTION	2000	11,787	786	15	786		786	11
12	UPGRADE SPRINKLER PIPING	2000	10,825	433	25	433		433	12
13	NURSE CALL SYSTEM 2 NORTH	2000	5,267	263	20	263		263	13
14	REPLACE 2 15HP CIRCULATION PUMPS	2000	11,288	753	15	753		753	14
15	GENERATOR UPGRADE	2000	1,626	81	20	81		81	15
16	EXPANSION TANK FOR BOILER	2001	2,780	185	15	185		278	16
17	FIRE ALARM NETWORKING	2001	2,041	102	20	102		153	17
18	CABLW/WIRE 2SOUTH COMPUTERS	2001	2,801	140	20	140		210	18
19	TOSHIBA VOICE MAIL SYSTEM	2001	5,156	516	10	516		773	19
20	SOUND SYSTEM FOR CHAPEL	2001	8,150	272	15	272		272	20
21	REPAIR FIRE SPRINKLER SYSTEM DEFICEINCIES	2001	4,715	94	25	94		94	21
22	REPLACED HOT WATER STORAGE TANK	2001	3,150	79	20	79		79	22
23	NURSE CALL SYSTEM 3,4 NORTH	2001	11,826	296	20	296		296	23
24	5 TON ROOFTOP AIR CONDITIONER KITCHEN	2002	6,100	305	10	305		305	24
25	CHILLER SE WING	2002	26,230	874	15	874		874	25
26	90 SMKE SMART DETECTORS	2002	1,756	59	15	59		59	26
27	SPRINKLER SYSTEM REPAIR	2002	2,980	60	25	60		60	27
28	REPLACED AIR SEPARATOR	2002	2,810	94	15	94		94	28
29	REPLACED CENTER BOILER SECTION	2002	5,328	178	15	178		178	29
30									30
31	DEPRECIATION ON DISPOSED ASSETS			1,335	10,15,25	1,335			31
32	ROUNDING		(7)	(6)		(6)		(7)	32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,436,612	$ 288,340		$ 288,340	$	$ 4,470,078	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,436,612	$ 288,340		$ 288,340	$	$ 4,470,078	1
2	LAND IMPROVEMENTS								2
3	FOUNTAIN	1975	2,807		25			2,807	3
4	FLAG POLE	1978	495		10			495	4
5	PARKING LOT & CURB	1979	6,425		10			6,425	5
6	1992 IMPROVEMENTS	1992	56,865	1,845	10	1,845		56,835	6
7	1995 IMPROVEMENTS	1995	18,601	1,550	12	1,550		11,496	7
8	BRICK WALL 5TH WASHINGTON	1997	4,800	192	25	192		1,056	8
9	PARKING LOTS 500,501,503 WASHINGTON	1999	44,219	3,685	12	3,685		12,898	9
10	FIRE HYDRANT INSTALLATION	2000	5,383	359	15	359		2,512	10
11	LANDSCAPE WHITE ROCK 4TH ST	2000	3,784	378	10	378		2,648	11
12	LANDSCAPE YARD	2000	1,700	170	10	170		1,190	12
13	IRRIGATION SYSTEM	2000	3,692	148	25	148		222	13
14	REMOVE REPLACE CONCRETE	2000	3,000	200	15	200		300	14
15	SHRUBS LANDSCAPING	2001	1,952	195	10	195		293	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,590,335	$ 297,062		$ 297,062	$	$ 4,569,255	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 632,243	$ 57,577	$ 57,577	$	5 TO 25	$ 360,575	71
72	Current Year Purchases	47,906	3,509	3,509		5,10,15	3,509	72
73	Fully Depreciated Assets	165,413					165,413	73
74	DEPR ASSETS DISPOSED		3,143	3,143				74
75	TOTALS	$ 845,562	$ 64,229	$ 64,229	$		$ 529,497	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINTENANCE	1997 3/4 TON GMC & PLOW	1997	$ 23,521	$ 3,089	$ 3,089	$	4,5	$ 23,323	76
77	RESIDENT TRANSPORT	2001 E-450 FORD BUS	2001	56,836	5,684	5,684		5	5,684	77
78	RESIDENT TRANSPORT	1994 FORD VAN	1995	36,216				4	36,216	78
79										79
80	TOTALS			$ 116,573	$ 8,773	$ 8,773	$		$ 65,223	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,741,177	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 370,064	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 370,064	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,163,975	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	VILLA INDEP LIVING UNITS	$ 1,677,631	$ 40,772	$ 581,871	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 1,677,631	$ 40,772	$ 581,871	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

COMMUNITY COLLEGE TRAINS AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 30,384	$		$ 30,384	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			3,480			3,480	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			1,728			1,728	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				28,113		28,113	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 35,592	$ 28,113		$ 63,705	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 122,079	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	576,184		3
4	Supply Inventory (priced at COST)	55,391		4
5	Short-Term Investments	594,717		5
6	Prepaid Insurance	45,092		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,393,463	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	170,754		12
13	Land	188,707		13
14	Buildings, at Historical Cost	9,590,335		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	962,135		16
17	Accumulated Depreciation (book methods)	(5,163,975)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,059,770		21
22	Other Long-Term Assets (spe SEE ATTACHED	2,711,894		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,519,620	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,913,083	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 84,104	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	419,904		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	HEALTH CLAIMS INCURRED	61,262		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 565,270	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	REFUNDABLE FEES	119,950		43
44	DEFERRED REVENUES	45,347		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 165,297	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 730,567	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,182,516	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,913,083	$	48

***(See instructions.)**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,977,734	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,977,734	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	204,782	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 204,782	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 11,182,516	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,842,909	1
2	Discounts and Allowances for all Levels	(694,874)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,148,035	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	4,584	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,100	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,684	23
	D. Non-Operating Revenue		
24	Contributions	592,822	24
25	Interest and Other Investment Income***	193,466	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 786,288	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SEE ATTACHED	160,062	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 160,062	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,103,069	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,801,955	31
32	Health Care	3,740,578	32
33	General Administration	1,684,448	33
	B. Capital Expense		
34	Ownership	417,713	34
	C. Ancillary Expense		
35	Special Cost Centers	162,160	35
36	Provider Participation Fee	91,433	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,898,287	40
41	**Income before Income Taxes (line 30 minus line 40)****	204,782	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 204,782	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,838	2,086	$ 52,682	$ 25.26	1
2	Assistant Director of Nursing	1,778	2,161	47,114	21.80	2
3	Registered Nurses	21,016	23,060	406,995	17.65	3
4	Licensed Practical Nurses	65,010	71,773	1,034,570	14.41	4
5	Nurse Aides & Orderlies	142,006	155,019	1,456,198	9.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,058	13,244	174,046	13.14	8
9	Activity Director	1,857	2,086	27,905	13.38	9
10	Activity Assistants	11,628	12,430	90,172	7.25	10
11	Social Service Workers	5,806	6,431	64,892	10.09	11
12	Dietician					12
13	Food Service Supervisor	1,877	2,086	33,574	16.09	13
14	Head Cook	1,859	2,086	27,430	13.15	14
15	Cook Helpers/Assistants	44,385	48,445	373,311	7.71	15
16	Dishwashers	6,904	8,063	67,243	8.34	16
17	Maintenance Workers	10,346	11,231	119,269	10.62	17
18	Housekeepers	26,782	29,350	217,119	7.40	18
19	Laundry	4,934	5,798	48,499	8.36	19
20	Administrator	1,818	2,087	75,085	35.98	20
21	Assistant Administrator					21
22	Other Administrative	6,897	7,770	123,225	15.86	22
23	Office Manager					23
24	Clerical	14,344	16,352	164,449	10.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,064	3,271	28,965	8.86	31
32	Other Health C: SEE ATTACHED	7,951	8,641	84,988	9.84	32
33	Other(specify) SEE ATTACHED	4,662	5,220	81,982	15.71	33
34	TOTAL (lines 1 - 33)	398,820	438,690	$ 4,799,713 *	$ 10.94	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 7,209	1-3	35
36	Medical Director		3,900	10-3	36
37	Medical Records Consultant		1,590	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,614	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,747	11-3	44
45	Social Service Consultant		1,747	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 20,807		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY KIRLIN	CEO/ADMIN	0	$ 75,086
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,086

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
TIMOTHY J WIEWEL CPA	AUDITING/ACCTG	$ 13,000
SCHOLZ LOOS PALMER SIEBER	LEGAL	6,551
SCHOLZ LOOS PALMER SIEBER	LEGAL	686
FROST & RUTTENBERG	MEDICARE ACCTG	9,493
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 29,730

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,003
Unemployment Compensation Insurance	8,153
FICA Taxes	357,938
Employee Health Insurance	366,700
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION	116,880
DISABALITY INSURANCE	6,788
PHYSICALS	6,918
EMPLOYEE AWARDS	19,290
UNIFORMS	226
ADJUST FUND DEVELOPMENT COSTS	(10,067)
TOTAL (agree to Schedule V, line 22, col.8)	$ 969,829

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	25,354
Health Care Worker Background Check	
(Indicate # of checks performed 7)	84
LIFE SERVICES NETWORK DUES	9,614
TRI STATE HEALTH CARE COALITION	3,896
OTHER VARIOUS DUES	7,152
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,100

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	22,473
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22,473

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/01 Ending: 9/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LIFE SERVICE NETWORK $9,614

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? YES If YES, what is the capacity? 220

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 70,474 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 91,433
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? YES Indicate the amount. $ 30,748

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: TIMOTHY J WIEWEL CPA The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.